of this year. On Oct. 7, 1934, in a review of my book on B.C.G., in which I advocated it as safe and successful, you said: "These views are very similar to those which have been advanced in the editorial columns of the *B.M.J.* during the past few years, and are likely to meet with a considerable measure of approval. The real crux of the matter is how great and how lasting is the degree of immunity produced."

I think Dr. Lillingston's fears are justified; we *have* been caught napping in this country—but not through any fault of yours, Mr. Editor, or mine.—I am, etc.,

Henley-on-Thames. K. NEVILLE IRVINE.

Temperature in Pulmonary Tuberculosis

SIR,—There have been a number of articles in the *Journal* about the temperature in pulmonary tuberculosis, especially in connexion with the menstrual cycle: Feb. 9 (p. 209), March 2 (p. 334), and April 6 (p. 523). In the *Journal* of Dec. 29, 1928 (p. 1173), I wrote on "The Temperature in Pulmonary Tuberculosis."

The oral method is the most suitable for taking the temperature, but the patient must keep his or her mouth shut for fifteen minutes, and the thermometer should be kept in for five minutes for accuracy. I noted the following points. (1) There was a definite premenstrual rise in temperature, the average duration of which was five to six days. The long premenstrual rise is present in only 34% of positive cases, but in 52% of negative cases. Two healthy nurses took their own temperatures at my request, and in both cases there was a premenstrual rise. This seems to show that it is not diagnostic of tuberculosis. In fact, if only one record of temperature is taken, it must be considered in relation to the menstrual cycle. (2) I also noted that in 90.1% of males the difference between morning and evening temperatures was more than 1° F. 0.56° C.), and in 56.7% of females less than 1° F.—I am, etc.,

Dorridge, Birmingham. COLIN MILNE.

Stethoscope versus X Rays

SIR,—Dr. J. Frankland West (Feb. 2, p. 182) describes a case in which the radiological diagnosis was that of a resolving lobar pneumonia, though the patient actually was suffering from pulmonary tuberculosis. From this case Dr. West concludes that a vote of "no confidence" with regard to mass miniature radiography is justifiable, and also that the *x*-ray film is inferior to the stethoscope in the diagnosis of early tuberculosis. Frankly I fail to see how a medical man with years of training behind him can arrive at such a conclusion on the scanty and feeble evidence put forward.

The clinician who relies on others for his *x*-ray interpretations is apt to forget that we can ask an *x*-ray film—and particularly one of the chest—just so much and no more. He feels that in order for such a film to be of any use it must supply an exact answer to the question, "From what disease is this patient suffering?" This belief is often fostered by the unwary radiologist who is tempted to read his films in terms of "bacteriology" instead of "pathology."

The *x*-ray film is a shadow picture of a disease process in an anatomic structure, and often cannot, and should not, be interpreted in the light of the causative organism. Yet this apparently is what Dr. West feels that it should be capable of doing before he is willing to grant it its rightful place in chest diagnosis. He is asking too much of his chest films, and because on occasions he gets the wrong answer he is ready to condemn the most useful diagnostic means at our disposal. Would Dr. West drive a screw with a hammer? And if he did try to do so without success would be then condemn the hammer as a useless tool? Would he condemn the microscope because it failed to tell him the difference between a tubercle bacillus and, say, a leprosy bacillus?

Nevertheless he attempts to belittle the value of the *x*-ray film when he once fails to get from it a differentiation between a tuberculous pneumonia and a resolving lobar penumonia, two conditions which may very strongly resemble one another. Any man with experience of chest radiology will admit that such differentiation is often quite impossible, and in Dr. West's case I have no doubt at all that the fault lay, not in the *x*-ray film, but in too great a readiness on the part of the radiologist to give a definite diagnosis on insufficient evidence. Those of us who give our whole time to chest work are constantly running across difficulties in accurate diagnosis on the basis of the *x*-ray film alone. A lung abscess may look exactly like a tuberculous cavity, while malignant glands in the mediastinum may be indistinguishable from the glandular involvement due to primary infection tuberculosis.

Nevertheless the *x*-ray film may be relied upon to reveal with accuracy pathological changes in the chest, even though on some occasions it gives no clue to the aetiology of the condition encountered. As a clinician who for the last fifteen years has been listening to patients' chests first and examining their *x*-ray films afterwards, I have no hesitation in saying that the skiagram will reveal many more early lesions than my stethoscope will bring to light. I use the word "lesions" advisedly, however, as in a number of cases it is impossible to be sure of the actual condition present without further laboratory and clinical examinations, and often another *x*-ray examination.

Dr. West has missed the point entirely when he expects a cut-and-dried diagnosis always to stare at him as soon as he opens the radiologist's report. Surely he would not ask for a vote of "no confidence" in his car when it failed to negotiate a three-foot depth of water. Yet this is exactly what he is doing when he asks an *x*-ray film too much and occasionally gets a wrong answer.—I am, etc.,

King George V Jubilee Memorial Sanatorium, Jamaica. RICHARD A. S. CORY, Senior Medical Officer.

SIR,—I hasten to explain that the membership of my "fifth-rate provincial soccer club" (March 16, p. 410) was strictly limited to the clinical methods of investigation which were enumerated in the preceding paragraph. Persons—living, dead, or fictitious—were neither admitted nor included. I hardly thought that this explanation would be necessary, but Dr. Weatherhead's letter (March 30, p. 504) shows that one can never be too careful when using a comparison.

Dr. Weatherhead's statement that I am a "comparatively recent" recruit to the tuberculosis service is not only comparatively but absolutely untrue. If ten years—three and a half of which were spent in full-time hospital appointments (two years in a teaching hospital) and six and a half years in busy tuberculosis clinics—come under the heading of "comparatively recent" then I must admit that my English is considerably worse than Dr. Weatherhead thinks.—I am, etc.,

Woodford Green, Essex. F. KELLERMANN.

Words and Clear Thinking

SIR,—I read with considerable interest Dr. T. C. Beard's letter (March 16, p. 404). It seems to me that medicine is honeycombed with etymological inconsistencies, in many cases the same word showing a Greek prefix and a Latin suffix, such as that dreadful word "dysfunction." Surely it would be better to show lingual continuity by referring to a "malfunction" or "dyscrasia."

It would be useful if some efforts were made to standardize medical language. Two glaring examples of mental confusion are presented in the numerous alternative names for the barbiturate drugs and in the various pathological subdivisions of the nephritic lesion such as "acute diffuse glomerulo-tubular nephritis." As I once heard a learned physician say, "Azotaemic and hydraemic nephritis are good enough for me." Again, why in eliciting signs in the chest should it be said that "vocal fremitus" is increased or diminished, thus using an English and a Latin word in the same phrase? Or is it really to one's advantage to know that splenomedullary leukaemia is synonymous with myelocytic leukaemia? I well recall on a ward-round my chief reading out to us clerks the registrar's impressive differential blood count in which well over a dozen different types of cell were claimed to have been seen under the microscope. Among them was a group classed as "dictocyte." My chief, himself a blood expert, said blandly to us: "Dictocytes! What are they? Do they talk to you?" There is a tendency also to fix the incorrect proper name to certain things. In descriptions of lymphadenoma the giant cells are labelled Dorothy Reed or Sternberg cells, whereas they were first described by Sir Frederick Andrewes of Bart's and should be Andrewes cells. To give another example, Graves's disease was